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UNDUE INFLUENCE IN THE CONTEXT OF MEDICAL TREATMENT

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ABSTRACT

It is argued that the application of the doctrine of undue influence to patient's decisions in the context of medical treatment is ripe for development. The doctrine is capable of providing much needed protection for vulnerable patients if developed along lines suggested by its use in other contexts. Unfortunately, the Court of Appeal has recently missed an opportunity to develop the law in this way and it may be some time before another suitable opportunity is presented to the courts.

The doctrine of undue influence has a long pedigree as a means of aiding vulnerable persons whose will has been overborne by another. The law of equity aids victims of improper pressure by relieving them of the consequences of their decisions. As we shall see, in certain circumstances equity has also been willing to draw rebuttable evidential inferences of undue influence, as a matter of policy. Just about all the relevant case law, however, has been transaction based, and the full potential of the doctrine in the context of medical treatment is only just starting to be realised. It will be argued that the law of undue influence needs to be developed further if it is to give adequate protection to the rights of vulnerable patients. In particular, it will be argued that equity's willingness to invoke evidential inferences of undue influence in specific transaction-based circumstances should apply in specifiable medical contexts.

There are at present only two cases on undue influence in the context of medical treatment, both of which reached the Court of Appeal. The first, *Re T*,¹ was a case concerned with pressure put on a weakened patient by a close relative, leading her to refuse a blood transfusion. The second is the focus of this article, *U v Centre for Reproductive Medicine*,² which concerns the withdrawal of consent to posthumous storage and use of sperm when pressured to do so by a medical advisor. Taking these cases in reverse order, this paper will briefly summarise their key features before outlining the law of undue influence as it has developed in other areas. It will then be argued that there are powerful moral grounds for extending the law as it as developed in transaction contexts so that it offers protection proportionate to the vulnerability and interests of patients in the context of medical treatment.

U AND RE T

In *U*, the Centre for Reproductive Medicine, which is part of Bristol University, sought declarations from the court concerning storage and use of sperm removed during the treatment of a patient before his unexpected death. The wife of the deceased wished to have the opportunity to use this sperm in an attempt to bear a child. The clinic sought the court's permission to destroy the sperm or, in the alternative, to transfer it to another licensed clinic for storage and use. As we shall

see, the case turned on whether the withdrawal of consent to posthumous use by the now deceased had been voluntary.

The couple, Mr and Mrs U, had approached the clinic after an unsuccessful operation to reverse Mr U's vasectomy. The day before Mr U underwent a successful operation to remove his sperm, he completed a form provided by the clinic on which he had ticked boxes indicating that he consented to storage and use of his sperm after his death. According to Mrs U's evidence, accepted as accurate by the court, after signing the form he had said to his wife, "There you go. If I die you can have my baby still."³

The extracted sperm was stored and just over a month later the couple attended a meeting with a specialist nursing sister at the clinic. At this meeting Mr U was asked to alter the form, as the "ethical policy" of the clinic (strongly supported by the nursing sister) was against posthumous treatment. This meeting took place two days before Mrs U was due to receive treatment, some four and a half months after the couple's first consultation at the clinic. In evidence, Mrs U claimed that it was "strongly implied" that continuation of treatment was conditional upon Mr U changing his form.⁴ The nursing sister gave evidence that the treatment would merely have been postponed until after counselling. Nonetheless, Butler-Sloss P at first instance thought that "the pressure must have been considerable",⁵ and the Court of Appeal noted that the couple "had already committed themselves, mentally, emotionally, and financially, to the course of treatment" and "were both very vulnerable."⁶

Unfortunately, the treatment following the meeting was unsuccessful and Mr U died unexpectedly shortly after. The clinic then made an application to the court, which was heard a year after Mr U's death.

The President of the Family Division held that the pressure placed on Mr U did not amount to undue influence, as something more than pressure was required; the patient's will must have been overborne. It followed that the withdrawal of consent was to stand. Hale LJ, giving the judgment of the Court of Appeal, upheld the President's decision that the sperm was to be destroyed. As we shall see, however, it is not entirely clear whether the Court of Appeal supported the full details of the President's analysis of undue influence.

The only case law cited to the President, and the principal case explored by the Court of Appeal, was *Re T*. Like *U*, *Re T* was concerned with pressure put on a patient to withdraw consent in the context of medical treatment. In *Re T*, however, the pressure was not from the medical team treating her. *T* was a pregnant woman who had been injured in a car accident and refused a blood transfusion after a meeting with her Jehovah's Witness mother. The patient was in a weakening condition and had previously stated that she was not a Jehovah's Witness. After undergoing a caesarean section the patient became unconscious and in need of a blood transfusion. Her father and boyfriend applied to the court to authorise such a blood transfusion. The Court of Appeal set aside the pregnant woman's prior refusal on the basis that she had been temporarily incompetent *and* her will had been overborne by her mother.

It is this second ground that concerns us here. On this Lord Donaldson of Lynton had stated that,

The real question in each such case is "Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?"⁷

He went on to state that when considering the effects of outside influences two aspects were of crucial importance: the strength of will of the patient and the relationship of the “persuader” to the patient. Butler-Sloss P was keen to apply this test in *U*. She also cited dicta from Staughton LJ’s judgment, but as noted by the Court of Appeal, she did not cite her own judgment where she had stated that “in equity it has long been recognised that an influence may be subtle, insidious, pervasive and where religious beliefs are involved especially powerful”.⁸

THE DOCTRINE UNDUE INFLUENCE

Before examining the application of *Re T* in *U* by the High Court and the Court of Appeal, it is useful to outline the doctrine of undue influence as it has developed outside the context of medical treatment.

There is a large body of case law on transactions induced by improper pressure. The most recent line of which has been concerned with improper pressure being applied by a husband to persuade his wife to stand her interest in the matrimonial home as security for his indebtedness (hereafter the “surety wife cases”). The surety wife cases are, however, somewhat removed from the present situation as the victim is not usually seeking a remedy against the wrongdoer—indeed, the wrongdoing husband is often supporting his wife in her attempt to prevent the lender relying on its security. Consequently, in these cases the courts have often focused more on the doctrine of constructive notice,⁹ than on undue influence. Nonetheless, the two leading surety wife cases—*Barclays v O’Brien*¹⁰ and *Royal Bank of Scotland v Etridge*¹¹—do provide enlightening analysis of the doctrine of undue influence.

Building on a distinction first drawn in the nineteenth century,¹² Lord Browne-Wilkinson in *O’Brien* distinguished cases where undue influence has to be affirmatively proved (class 1 or actual undue influence) from cases where the relationship between the parties will lead the courts to presume undue influence (class 2 or presumed undue influence). Following an earlier decision of the Court of Appeal,¹³ he further divided class 2 cases into two categories. The first, class 2A, was said to encompass certain relationships that “as a matter of law raise the presumption of undue influence has been exercised”.¹⁴ The second, class 2B, was said to encompass those situations where the complainant “proves the de facto existence of a relationship under which the complainant generally reposed trust and confidence in the wrongdoer.”¹⁵

In *Etridge*, their lordships emphasised that the class 2 presumption was no more than an “evidential rebuttable presumption,” shifting the onus from the party alleging undue influence to the party who is denying it.¹⁶ The weight of this presumption (or inference) and the evidence needed to rebut it will depend on the nature of the relationship and the nature of the transaction.¹⁷ Thus, if a transaction is challenged where the relationship between the parties is one of trust and confidence (either presumed or proven)¹⁸ and the nature of the transaction calls for an explanation, the party denying undue influence will bear the burden of proving that the transaction was not the result of improper pressure.

As stated above, the only decision considered by the High Court and the only decision considered in any depth by the Court of Appeal in *U* was *Re T*. Perhaps, this was because the surety wife cases and other cases on undue influence were only concerned with transactions, rather than medical treatment. Indeed, in *Re T* Butler-

Sloss LJ denied the relevance of the “probate line of cases” and “the donor line of cases”¹⁹ and agreed with Staughton LJ who held,

The cases on undue influence in the law of property and contract are not, in my opinion, applicable to the different context of consent to medical or surgical treatment. The wife who guarantees her husband's debts, or the widower who leaves all his property to his housekeeper, are not in the same situation as a patient faced with the need for medical treatment.²⁰

There are, indeed, differences between a decision on a transaction and a decision on medical treatment. In *Re T*, for example, the decision was of a different order of importance—it was one of a life-and-death. The potentially greater importance of decisions on medical treatment, however, offers no reason for rejecting the distinction (albeit only an evidential distinction) between actual and presumed undue influence. Nonetheless, both *Re T* and *U* are, in effect, treated as cases of alleged actual undue influence; i.e., class 1 undue influence. In *U* counsel seems to have conceded that medical law cases (or at least this one) could not give rise to a presumption of undue influence. According to Hale LJ,

Mr Treverton-Jones QC, on behalf of Mrs U, accepts that the burden of proving undue influence lies upon her. This is not a situation in which undue influence is to be presumed.²¹

It will be argued that this concession was unnecessary, as there are good policy reasons why the situation in *U* ought to be one where the law is willing to invoke a presumption of undue influence as least as strong as that invoked in class 2A situations.

PRESUMED UNDUE INFLUENCE AND DIRECTIVE COUNSELLING

As stated above, both *Re T* and *U* were treated as cases falling into class 1 (actual) undue influence in which the parties wishing to set aside the effects of his/her decision bears the onus of proving improper pressure. In *U*, the decision at first instance suggests that Mrs U came very close to discharging the onus of proof, as Butler-Sloss P thought that the “evidence was finely balanced”. Nonetheless, she went on to state that

it is difficult to say that an able, intelligent, educated man of 47, with a responsible job and in good health, could have his will overborne so that the act of altering the form and initialling the alterations was done in circumstances in which Mr U no longer thought and decided for himself....[Mr U] succumbed to the firmly expressed request of...[the nursing sister] and under some pressure. But to prove undue influence, Mrs U has to show something more than pressure. As Lord Donaldson said in *re T*, it does not matter how strong the persuasion was so long as it did not overbear the independence of the patient's decision.²²

Thus, according to Butler-Sloss P, “an able, intelligent, educated man of 47, with a responsible job and in good health” would not be expected to succumb to “considerable”²³ pressure put on him by a medical advisor. With all due respect, a patient with no medical training seeking medical treatment is in an inherently vulnerable position. Although the factors cited by the President suggest an ability to think independently, these attributes are likely to be weakened by the degree of trust

typically vested in medical opinion and the emotional vulnerability of most patients. In *U* itself, the key person, Mr U, was obviously unable to present evidence. Moreover, at the time when the pressure was applied he had no reason to think that the clinic would be in a position where his views on posthumous storage and use would have any practical consequence—he had no reason to anticipate an early death. If in a position where one is asked to change an official statement of one’s views where the costs of not doing so appear to be high (Mr U believed that treatment would stop) and the consequences of doing so appear to be negligible (an early death seemed no more than a remote possibility and he might well have intended to reassert his views with regard to any surplus sperm following successful treatment),²⁴ even a small amount of pressure will be sufficient to overbear one’s will. An intelligent and educated person in such a situation might well agree with the nursing sister for (to use the words of Lord Donaldson cited above) “a quiet life” without really meaning “what he says”. To put it another way, given Mr U’s apparent desperation to have a child, his actions are entirely consistent with accession to undue influence.

Not surprisingly the Court of Appeal was asked to apply the President’s own dicta from *Re T* to the effect that improper pressure can “subtle, insidious, pervasive and where religious beliefs are involved especially powerful”. The Court of Appeal, however, refused to overturn the President’s decision.

It is submitted that this case represents a missed opportunity to develop the law along justifiable lines. We have seen that in a transaction-based context equity has been willing to invoke presumptions of undue influence. The justification for evidential presumptions is policy based; the presumptions serve to protect vulnerable persons by diluting the evidential burden that they face. As Lord Scott of Foscote put it in *Etridge*, when considering so-called class 2A undue influence, “[t]here are some relationships, generally of a fiduciary character, where, as a matter of policy, the law requires the dominant party to justify the righteousness of the transaction”.²⁵ In the context of transactions the relationship between patient and medical advisor is accepted to be one falling within class 2A,²⁶ where the law will irrebutably presume the requisite trust and confidence, and place the burden of proof on the shoulders of the medical advisor where the transaction is one that calls for an explanation.

It is submitted that *U* represents an instance of a type of case where the law ought to invoke a presumption of improper pressure. Let me first outline the requisite features of what I submit should become a new category of presumed undue influence. It is argued that undue influence ought to be presumed where the patient proves

- (a) the relationship between the parties is one of patient and medical advisor;
- (b) the medical advisor has put pressure on the patient to reach a particular decision (i.e., the decision reached); and
- (c) the patient needs persuasion for reasons other than an initial failure to understand the full details of relevant medical science.

It should be clear from these criteria that what I have in mind might be called directive counselling, i.e., where a medical advisor seeks to press his/her own ethical views upon the patient. Moreover, the term “medical advisor” is being used to cover those purporting to have medical expertise and advising/counselling patients on the basis of that expertise. Doctors and nurses are paradigmatically medical advisors so defined.

Criterion (a) defines a relationship that, as a matter of policy, the law recognises to

be one of trust and confidence in other contexts. This relationship is one where one party, the patient, is particularly vulnerable because it is formed where that party seeks to rely on the expertise of the other at a time of need, uncertainty, and, often, ill health. Criterion (b) and (c) serve to provide greater specification for a modified version of the second requirement applying to transactions, namely, the requirement that the transaction be one that calls for an explanation. In other words, where (b) and (c) exist in the context of (a), the patient's decision calls for an explanation, so that it is appropriate for the medical advisor to bear the burden of showing that undue influence has not been applied.

I submit that these three criteria are sufficient (but by no means necessary) conditions for the imposition of a rebuttable inference of undue influence in the context of medical treatment. The justification for this conclusion rests on a number of considerations in addition to the need to protect the vulnerable.²⁷ First, medical advisors are typically subjects of respect and authority and such power should be exercised responsibly. Second, medical advisors are not necessarily ethically qualified; their position is defined by medical expertise. Third, patients have a right to autonomous self-determination. Fourth, where a medical advisor has an ethical or religious objection to a legally available treatment or service, it is an abuse of position for that medical advisor to use his/her post to impose those views. In the context of abortion, for example, the law recognises that it is inappropriate to force doctors who object to abortion on ethical grounds to prevent a patient gaining access to abortion and doctors are under a legal duty to direct the patient to a doctor without such ethical objections.²⁸

To be clear, I am arguing for a rebuttable evidential inference of undue influence, analogous to class 2A undue influence in the context of transactions, where the three criteria above are satisfied. Thus, where these three criteria are established, the patient's will should be presumed to be overborne. Moreover, evidential obstacles should not be placed in the way of establishing these criteria. Criterion (b), for example, could, in appropriate circumstances, be established by the existence of a stated ethical policy.

If sound, this reasoning would apply with some force to *U*. Since, on the facts, the "evidence was finely balanced", it is clear that the Centre for Reproductive Medicine would not have been able to rebut an evidential inference of undue influence. I would go further and argue that this inference should only be capable of being rebutted by clear and compelling evidence, such as proof that the patient has been provided with independent advice and the details of an appropriate alternative supplier of the treatment or service. What is sufficient must vary according to the circumstances. In *U*'s case, for example, the late stage at which the pressure was applied should have made rebutting any such inference very difficult indeed.

I have not yet explored any competing policies or factors to those that I suggest support an inference of undue influence where my three criteria are satisfied. A counter argument, applying in specifiable instances, is suggested by the Court of Appeal's decision in *U*. As stated above, although it is clear that the Court of Appeal supported the President's conclusion it is not clear whether it supported the entirety of her analysis on undue influence. In response to an argument by counsel for Mrs U to the effect that the President had applied the wrong legal test for (actual) undue influence, Hale LJ asserts that this was not the question faced by the court.²⁹ She then went on to analyse effective consent under the Human Fertilisation and Embryology Act 1990 (hereafter HFE Act). It is submitted that it is, therefore, possible to view the *ratio* of the Court of Appeal's decision as either

- (a) upholding the President's analysis of undue influence, but restricting it to effective consent under the HFE Act *or*
- (b) rejecting at least some part of the President's analysis of undue influence but holding that, in the context of the HFE Act, the President's decision was correct.

Hale LJ distinguished the transaction-based case law on undue influence by, *inter alia*, asserting that in those cases there was some other justification for disapplying the questioned decision, whereas "[t]here is no other justification [in the absence of effective consent] for continuing to store human sperm".³⁰ Thus,

a Centre having in their possession a form dealing with the matters with which it is required by schedule 3 to the 1990 Act to deal should be both entitled and expected to rely upon that form according to its letter, *unless and until it can clearly be established that the form does not represent a valid decision by the person apparently signing it*.... The equitable concepts of misrepresentation and undue influence may have a part to play but the courts should be slow to find them established in such a way as to supply a centre with a consent which they would not otherwise have.³¹

According to the Court of Appeal, it follows that the President did not apply too strict a test. This might be read as suggesting that the policy of the HFE Act renders it inappropriate for a presumption of undue influence to operate.

Drawing on the Court of Appeal's decision, two aspects of the HFE Act might be thought to have a bearing on my argument for a presumption of undue influence.

First, for posthumous storage and use of gametes the Act requires effective (written and not withdrawn) consent to prevent subsequent disputes and provide clear evidence that a posthumous child was wanted by both parents. The Court of Appeal suggests that the Act's underlying policy should render the court reluctant to interfere with the decision as stated on the face of the relevant documentation.

Second, the Act places a significant hurdle in the way of posthumous storage and use. The Act requires that account be taken of the welfare of the child who will be born or affected as a result, *including the need for a father* of any child born as a result of treatment,³² *and* any child born as a result of posthumous insemination is rendered *legally fatherless*.³³ This combination means that it is easy for a clinic to find that posthumous use is not in the child's best interests. Indeed, the licensing authority's code of practice asserts that clinics should explicitly consider whether the child will have no legal father and pay particular attention to whether the prospective mother will be able to meet the child's needs.³⁴ Perhaps not surprisingly, about a third of clinics do not perform posthumous insemination.³⁵

I submit that these two factors do not undermine my argument for an evidential inference of undue influence applying where the abovementioned three criteria apply in the context of posthumous storage and use of sperm.

The first argument did not prevent another panel of the Court of Appeal ignoring the Act's need for written consent in *R v Human Fertilisation and Embryology Authority, ex parte Blood* [1997].³⁶ As is well known, this was a case where sperm was removed from a comatose man and stored without his written consent, and his bereaved wife sought permission to export the sperm for treatment abroad. Admittedly, in the *Blood* case the Court of Appeal only condoned the (unlawful) storage of sperm on the basis that the cases presented an "unexplored legal situation", which the court thought would not occur again.³⁷ Nonetheless, ensuring that an

existing written statement provided in the context of assisted reproductive services is truly representative of the deceased's views is a much more compelling ground for judicial intervention than ensuring that the deceased views casually expressed outside the context of assisted reproduction are followed. Unlike Mr Blood, Mr U had consented in writing to posthumous storage and use as required by the HFE Act, but had withdrawn it under pressure.

The second argument is relevant to a clinic's decision on whether to provide posthumous insemination but, it is submitted, it should have no impact on who should bear the burden of proof with regard to the voluntariness of the deceased's expressed views. Three things need to be distinguished: a clinic's powers in relation to the treatment services it provides, a clinic's powers in relation to the storage services it provides, and a clinic's powers in relation to the counselling and advisory services it provides. Subject to the requirement that a public body must not fetter its discretion by operating an absolute policy,³⁸ it is perfectly legitimate for a clinic to refuse posthumous insemination in the exercise of its discretion under the HFE Act. Indeed, we have seen that under s.13 of the Act it is a condition of a clinic's treatment licences that it withhold treatment services (including the provision of posthumous insemination and implantation) where it considers such services not to be in the best interests of the child. This condition does not, however, apply to a clinic's storage licences, i.e., the clinic has no such discretion with regard to its storage of gametes under s.14 of the Act. Moreover, a clinic has no statutory power to direct its patients to accept its ethical views. Thus, what statutory support exists for denying posthumous insemination and implantation does not provide any statutory resistance to judicial use of evidential inferences of undue influence.

CONCLUSION

The law has long shown deference to the views of the medical profession,³⁹ even where the matter is inherently ethical rather than purely medical. In cases on the appropriate level of disclosure of information by doctors to their patients, for example, the courts have held that a medical advisor will not be negligent if s/he discloses only those risks that would have been disclosed by a reasonable doctor, rather than those risks that a reasonable patient, or a specific patient, would want disclosed.⁴⁰ As the courts now appear to be conceding,⁴¹ this undermines patient autonomy by granting the medical profession a discretion extending beyond their medical expertise. In a similar light, I have argued in this article that the operation of the doctrine of undue influence to medical treatment needs to be reconsidered to avoid undue deference to the ethical views of the medical profession and to protect vulnerable patients. More specifically, I have argued that vulnerable patients should be protected from overbearing ethical advice by an evidential presumption that any ethical pressure was sufficient to render the patient's decision involuntary.

NOTES

¹ [1992] 4 All ER 649.

² [2002] EWCA Civ 565 (hereafter CA). This case was first heard by the President of the Family Division: *Centre for Reproductive Medicine v U* [2002] EWHC 36 (hereafter FD).

³ FD, para. 16; CA, para. 11.

⁴ FD, para. 13.

⁵ FD, para. 22.

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- 6 CA, para. 21.
- 7 *Supra* note 1, 662
- 8 *Ibid.*, 667.
- 9 In traditional property law, a person is deemed to have notice (i.e., constructive notice, rather than actual notice or awareness) of a prior property right when he would have learned of it had he made appropriate inquiries. This doctrine was extended by the House of Lords in *Barclays Bank v O'Brien* [1994] 1 AC 180 as a means of preventing lender's enforcing their security in situations where they had failed to take (what the court considered to be) reasonable steps to ensure that the wife understood the transaction that she had entered into. Thus, where the lender fails to take such steps it has "constructive notice" of any factors undermining the voluntariness of the wife's agreement, so that the lender is preventing from relying on an involuntary decision.
- 10 *Ibid.*
- 11 [2001] UKHL 44.
- 12 *Allcard v Skinner* [1887] LR 36 ChD 145, particularly Cotton LJ at 171–172.
- 13 *Bank of Credit and Commerce International SA v Aboody* [1990] 1 QB 923.
- 14 *O'Brien*, *supra* note 9, 189.
- 15 *Ibid.*
- 16 *Supra* note 11, see particularly para. 16 (Lords Nicholls) and para. 153 (Lord Scott). Lords Nicholls, Scott, and Hobhouse drew an analogy between the presumption of undue influence and the doctrine of *res ipsa loquitur* in negligence: see para. 16 (Lord Nicholls), para. 161 (Lord Scott), and para. 107 (Lord Hobhouse).
- 17 *Ibid.*, see particularly Lord Scott, para. 153.
- 18 A relationship of trust and confidence is irrebutably presumed where it is, e.g., one of parent and child, guardian and ward, trustee and beneficiary, solicitor and client, and medical advisor and patient. Being husband and wife does not give rise to a presumption of trust and confidence, this has to be proven (see *O'Brien*, *supra* note 9, and *Etridge*, *supra* note 11).
- 19 *Supra* note 1, 667.
- 20 *Ibid.*, 669.
- 21 CA, para. 20.
- 22 FD, para. 28.
- 23 The words of Butler-Sloss P, see FD, para. 22.
- 24 It makes sense to wait until the disparity in power has been removed before fighting one's ground.
- 25 *Supra* note 11, para. 158.
- 26 It is, indeed, given as an example of such a relationship by a number of their lordships in *Etridge*, *ibid.*, see, e.g., para. 18 (Lord Nicholls) and para. 157 (Lord Scott).
- 27 Many of the considerations presented below are morally loaded and, therefore, require the support of a substantive moral theory. Elsewhere I have nailed my colours to a particular mast and supported a moral theory granting rights to the necessary conditions of acting at all or successfully to all those capable of adhering to moral or practical precepts: see Shaun D. Pattinson, *Influencing Traits Before Birth* (Aldershot, Ashgate, 2002) (forthcoming). The considerations outlined can be straightforwardly derived from this and many similar rights-based moral theories.
- 28 For a discussion of this point, see Andrew Grubb "Abortion" in Ian Kennedy and Andrew Grubb, eds., *Principles of Medical Law*, 609–649 (Oxford: Oxford University Press, 1998), para. 11.77. A conscientious objection to participating in abortion can be made, subject to conditions under s.4 of the Abortion Act 1967. Similarly, a conscientious objection to participating in any activity governed by the Human Fertilisation and Embryology Act 1990 can be made under s.38 of that Act.
- 29 CA, para. 23.
- 30 CA, para. 25.
- 31 CA, para. 26 (my emphasis).
- 32 S.13(5), HFE Act. I have reservations about the meaningfulness of asking whether it is in a future child's best interests to be part of a programme that is a necessary condition for its existence: see Shaun D. Pattinson "Wrongful Life Actions as a Means of Regulating Use of Genetic and Reproductive Technologies." (1999) 7 *Health Law Journal* 19 and "Reproductive Cloning: Can Cloning Harm the Clone?" (2002) 10(3) *Medical Law Review* (forthcoming). For the purpose of this article, however, I will not question the statutory reliance on the meaningfulness of this task.
- 33 S.28(6)(b). This requirement is ethically questionable. If its purpose is to safeguard certainty with regard to inheritance, this could easily have been achieved by a more specific provision to the effect that any child conceived after death will not have a claim on the dead man's estate.

³⁴ Human Fertilisation and Embryology Authority, *Code of Practice*, 2nd revision (London: HFEA, 2001), para. 3.15(a). The code also asserts that those seeking to consent to posthumous use of sperm must be informed that the HFE Act will render the resulting child legally fatherless (para. 7.22).

Although a failure to comply with the code does not, by itself, have legal consequences, the licensing authority is empowered to take account of such failures (see s.25(6) HFE Act).

³⁵ Statistic given in FD, para. 3.

³⁶ [1997] 2 All ER 687.

³⁷ See *ibid.*, 695 (per Lord Woolf MR). For criticism see Derek Morgan and Robert G. Lee, “In the Name of the Father? Ex parte Blood: Dealing with Novelty and Anomaly.” (1997) 60(6) *Modern Law Review*: 840.

³⁸ This is a well-established principle of public law, see, e.g., the decision of the House of Lords in *British Oxygen Minister of Technology* [1971] AC 610. Surprisingly, this principle has yet to be argued in any case on the HFE Act. It would, e.g., have been an appropriate argument for counsel to advance in *R v Ethical Committee of St Mary's Hospital Ex p Harriott* [1988] 1 FLR 512 and *R v Sheffield Health Authority ex parte Seale* (1994) 25 BMLR 1.

³⁹ The *Bolam* test—which protects medical practitioners from liability where they have acting in accordance with a responsible body of medical opinion—has arguably become a decision-making default in cases involving judicial consideration of medical treatment. It has not only been applied to determine the standard of care in a negligence actions with regard to medical diagnosis (*Maynard v West Midlands RHA* [1985] 1 All ER 635) and the management of patients (*Whitehouse v Jordan* [1981] 1 All ER 267), but also to the provision of medical advice on risks and benefits of treatment (*Sidaway v Bethlem Royal Hospital* [1985] AC 871). It has also been applied as a means of judging the adequacy of medical determination of the best interests of an incompetent adult (*F v West Berkshire HA* [1989] 2 All ER 545) and to the withdrawal of treatment from a patient in PVS (*Airedale NHS Trust v Bland* [1993] AC 789). This test has historically granted a greater amount of leeway to the medical profession (see, however, more recently: *Bolitho v City and Hackney HA* [1998] AC 232 and *Pearce v United Bristol Healthcare* (1999) 48 BMLR 118).

⁴⁰ See *Sidaway ibid.*

⁴¹ See, e.g., *Pearce ibid.* It appears that the courts are now inclined to take more patient-centred view of causation in disclosure of risk cases: see, e.g., *Chester v Afshar* [2002] EWCA Civ 724.